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ABSTRACT

This report was written to provide educators with information on their role in dealing with the problem of adolescent suicide. A review of current literature was conducted to give educators accurate teenage suicide information, and an annotated bibliography of relevant citations from that review is included. Thirty entries are organized in the areas of suicidal facts and statistical information, causal factors, warning signs and suicidal cues, prevention and intervention, and the educator's role. A glossary of relevant terms is included. A summary of information obtained from the research and literature review follows the bibliography. Suicidal warning signs are summarized and examples of situational, behavioral, emotional, and verbal clues which may indicate suicidal ideation are listed. Recommendations for educators are given. References are included. (NB)

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# AN EDUCATOR'S GUIDE TO THE LITERATURE DEALING WITH TEENAGE SUICIDE

by

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# STATEMENT OF THE PROBLEM

Young people across the country are taking their own lives at an increasing rate. The frightening statistics provided by the National Center for Health Statistics indicate a steady increase in the rate of adolescent suicide. The number of suicides by young people between the ages of 15 and 24 has risen dramatically in the past twenty-five years. In 1960, 1239 young people took their own lives. That number rose to 3128 in 1970, 5239 in 1980, and leveled off to 5026 in 1984. (National Suicide Statistics 1980:3)

While the actual number of suicides has grown, a better indicator of the problem is represented by the suicide death rate per 100,000 in population. In 1960, the suicide rate for the 15-19-year old group was 3.6. This rate grew to 8.7 in 1982. The 20-24-year old age group's rate grew even more dramatically from 7.1 in 1960, to 15.1 in 1982. (Weed 1985:137)

Suicide is a national problem that infects all areas of the country, and we in Indiana are not immune to this problem. In 1984, 105 of Indiana's young people took their own lives, which represents a rate of 10.7. (Youth Suicide :54) St. Joseph County had seventy-seven suicides from 1983-85. (St. Joseph County Health Department Annual Report 1985:14)

Suicide crosses sexual and racial boundaries, although white males are the most likely group to take their own lives. White males between the ages of 15 and 24 have shown a three-fold increase in suicide incidences since 1958. (Weed 1985:137) White males are the most likely group to commit suicide, while white females are 3 to 5.6 times more likely to attempt suicide.(Weed 1985:138) The discrepancies between the number of attempts and actual deaths in females can be explained by the lethality of chosen means. When males decide to attempt suicide, they are more likely to choose a more lethal instrument, such as a gun or hanging. Girls attempting suicide tend to use less lethal means, such as poisoning.

Estimates, derived from statistical data, suggest that in a typical high school with 2000 students there will be as many as 50 attempted suicides each year. Furthermore, every four years one such attempt will be successful. (Davis 1985:320) Smith's study indicates that 10.5% of all high school students had made one or more suicide attempts. Approximately 25% of the sample had planned a suicide attempt, while a staggering 62.6% reported some degree of suicidal ideation. (Smith 1984:2)

All studies on suicide suggest that the number of deaths reported as suicide is most likely under-reported.

Many suicides are labeled as "accidents" or listed as "cause unknown" by medical examiners. Many 'accidental' adolescent deaths, especially single car fatalities, very well could be labeled as suicide.

The problem is very real. Statistics show that each of our classrooms has a significant number of troubled young people. As educators we can no longer sit back and ignore this problem. Teachers have to realize most students have problems far beyond the scope of the subject matter.

## PURPOSE OF THE STUDY

Adolescence is a time of great change both physically and mentally. When young people traverse this time period between childhood and adulthood, they often become confused and disoriented. All people need stability in their lives, and young people are no exception. The school becomes a corner-stone in their lives, a place of stability. The teachers can be not only mentors but also role models and adult friends. The relationship with the teacher is most often the first adult friendship ever developed by the adolescent. The school is also the focal point of the adolescent's social life, a gathering place for hundreds of young people with many of the same growing pains. The troubled adolescent is searching for many answers, and this search will often lead to the teacher or the student's peer

group. When the teacher is singled out, his/her responsibility is two fold. The teacher must be very receptive to student needs and must be attentive to student suicidal tendencies. Educators must also provide suicide education to all students. Each student must be able to recognize a fellow student that is at risk. To carry out these charges, a thorough knowledge of suicide must be attained.

## ORGANIZATION OF THE STUDY

A study of adolescent suicide for the classroom teacher can be broken into five areas: facts and statistics, causal factors, warning signs and clues, intervention techniques, and the educator's role.

## LIMITATIONS OF THE STUDY

This study has a very unfortunate limitation; it can not prevent all adolescent suicides. Hopefully, it can help an educator to recognize someone at risk and possibly save a young life. This study may also help prepare for the counseling of survivors in the event that a suicide does take place.

## GLOSSARY

Adolescence - the teen years, characterized by ambivalence towards many things; a time of experimentation. (Youth Suicide 1985:5)

Age-adjusted rates - a direct computation by applying the age-specific death rates for suicide to the standard population distributed by age. If an age group has more members, it should have more suicides;thus, the adjusted rate is a better indicator of difference in age groups. (Weed 1985:165)

Age-specific rates - rates not only computed for age adjustment but also for categories, such as race and/or sex. (Weed 1985:167)

Alienation - characterized as a sense of powerlessness, isolation, self-estrangement, homelessness, and lonely frustration. (Youth Suicide 1985:7)

Ambivalence - simultaneous attraction toward and repulsion from oneself. (Ross 1985:150)

Compassionate Friends - name of a national organization with local chapters. (Youth Suicide 1985:68)

Confidentiality dilemma - occurs when you make a promise not to tell anyone about the matters being shared but are faced with a potentially serious situation and must seek help. (Youth Suicide 1985:35)

Depression - the most common mental illness. One of the most common maladies before a suicide attempt. (Youth Suicide 1985:13)

Distress clues - camouflaged signals sent out by the youth that can lead observers to recognize that the youth is having a suicidal crisis. (McIntosh 1987)

Empathy - the active participation in another's feelings; a condition of feeling what another feels. (Mandle 1984:120)

Installment plan suicide - unconscious self-destructive acts such as, reckless driving, alcohol or drug abuse. (Youth Suicide 1985:18)

Intervention - methods to be used to help a adolescent overcome an suicidal crisis. (Shamoo 1985:297)

Lethality (assessment of risk) - evaluation of the seriousness of the adolescent's suicidal threat; evaluate if they have the means at hand and if they have a plan. (Shamoo 1985:298)

Masked depression - depression turned outward by causing trouble, running away, or substance abuse. (McIntosh 1987)

Ontological - based upon being or existence, about the nature of being or the kinds of existence. (Young 1985:57)

Peer support programs - programs set up in school to lend group support in time of crisis. (Youth Suicide 1985:10)

Risk - a person that possesses suicidal ideation. (Youth Suicide 1985:13)

Significant other - very close friend, usually a boyfriend, girlfriend or a spouse. (McBrien 1983:78)

Suicide - derived from the Latin word suicidium, "the taking of one's own life"; a voluntary act of causing one's own death that was intended or hoped for. (Young 1985:55)

Suicide rate - computed by rates: number of suicides in a group divided by the population of the group, times 100,000. (Advance Report of Final Mortality Statistics 1984)

Survivors' support groups - groups formed after a suicide to help remove guilt feelings that survivors often develop. (Youth Suicide 1985:48)

Sympathy - an external effect of a person's feelings to another, parallel feelings. (Young 1985:57)

# ANNOTATIONS

## SUICIDAL FACTS AND STATISTICAL INFORMATION

"Advance Report of Final Mortality Statistics, 1984,"Report by The U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, Mortality Statistics Branch.

The report indicates that the slight declines in the suicide rate in 1982 and 1983 may have been just a temporary reversal of the 30-year trend of an increasing suicide rate. The "84" report shows that suicide has again taken over as the second leading cause of death in the 15-24 year old age group. The 1984 data showed a 5% suicide rate increase over 1983.

"Death and Death Rates from Suicide in the United States from 1960-80,"Report by The Division of Vital Statistics, National Center for Health Statistics.

Yearly death rates from suicide for the ages 15-19 and 20-24 were compiled by the National Center for Health Statistics. The data were broken down into categories of actual number and rate. Both categories were subdivided into columns headed by race and sex for each year,1960 to 1980.

The stat-sheets were easy to read and showed a dramatic climb in rates overall. Distinctive difference in the columnized catagories of race and sex were easily discernible.

"Final 1983 Suicide Statistics," Report by The U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, Mortality Statistics Branch.

The final 1983 suicide statistics were a collection of data covering all causes of death in the United States. The data were separated into several categories including age groups, causes of death, states where deaths happened, and race. The statistics indicated a slight decline in the 1983 suicide rate over the 1982 rate. The decrease was not significantly different from the previous years. The statistics indicated that for 1983 suicide in the 15-24 year old age group ranked a close third in leading causes of death.

"Monthly Vital Statistics Report," Provisional Data from the National Center for Health Statistics, Vol.34 No.13 (September 19,1986), pp 7-22.

This report contained the vital statistics for 1985, listed and ranked by the fifteen leading causes of deaths. A graph was provided showing the death rate for the leading causes of death for the years, 1950-85. A table comparing death statistics of 1984 with those of 1985, broken down by age groups, was supplied. This report was based on the preliminary data as compiled by state health agencies. The report shows an increase in suicides in the 15-24 year old age group.

"Nationwide Suicide Statistics, (ages 10-24)," Report by The National Center for Health Statistics, 1980.

The statistical results were listed by state and broken down into three age group ranges- 10-14, 15-19, and 20-24. The number of suicides per state was in correlation with the population of that state. The suicide rate from state to state was consistent with the national norm. Illustrated graphs were also provided.

Plain, George, M.D., St. Joseph County Health Department Annual Report 1984, 11-14.

The Annual Report, a book put out by the county health officer, was a synopsis of all health department activities for the year. In this report Dr. Plain categorized all deaths in St. Joseph for the three year period 1982-84. It is Plain's job to determine the cause of death and to sign the death certificate. In the three year period of the report he certified seventy-six deaths by suicide.

Plain, George, M.D., St. Joseph County Health Department Annual Report 1985, 11-14.

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## CAUSAL FACTORS

American Academy of Pediatrics, "Q & A on Adolescent Suicide", PTA Today. November 1985, 17-18.

The paper was prepared by the A.A.of P. to give some basic facts of adolescent suicide and to answer four related questions: (1) Why the increase in suicide? (2) Why warning signs precede suicide? (3) What is normal depression? (4) Why are there cluster suicides among adolescents? The Academy stated that 70 percent of all adolescent suicide victims had alcohol in their systems, and 75 percent had seen a doctor within one month prior to their death. The authors contend that alcohol numbs the feelings and lowers the resistence to self-harm. The visit to the doctor was seen as the victim's attempt to communicate with someone that could help them in their crisis.

Formica, Richard F. Ph.D., "What the Experts Don't Tell You About Teenage Suicide," McCall's, Oct. 1985, 82-87.

Formica took a refreshingly positive look at adolescents, with a reminder that most teens are not suicidal. Formica's contention was that most adolescents, suicidal or not, pass along the same suicidal warning signs. Those symptoms were a result of the very nature of adolescence, a time of great change. The author concluded that adolescents' suicidal ideations were an outgrowth of their yearning to be understood. The need to be fully understood could not be fulfilled by the suicidal child because of poor communication skills or a feeling that there was no one with whom to communicate. Formica concluded that better communication skills coupled with improvements in active listening by parents and educators would help to reduce the incidence of teenage suicide.

Mandle, Carol Lynn, "Suicide A Human Problem," Educational Horizon, 62 (Summer 1984), 119-21.

The World Health Organization estimated that 30,000 people committed suicide in the United States in 1985. Suicide was the second leading cause of death among adolescent males in 1985.

Mandle referred to suicide as a very private and personal form of human expression. Many religious, scientific, and philosophical theories were investigated and this summary was presented by Mandle: "Most suicidal attempts occurred when, and only when, all significant relationships were broken. The patient after communicating, testing, and searching for hope, felt he/she was all alone in an empty world." Adolescence is a time when strong interpersonal relationships are developed. An interruption in this development can be caused by a death of a loved one, divorce, attendance at a new school, a move, a new job, illness and so forth. This interruption can generate feelings of inadequacy and spawn lack in self-esteem. It appears that one's relationship with others can be a strong indicator of one's vulnerability to suicide. Mandle's article makes a good basis for other research but lacks depth and solutions.

Mercy, James A., Tolsma, Dennis., Smith, Jack C., and Conn Judith M., "Patterns Of Youth Suicide in the United States," Educational Horizon, 62 (Summer 1984), 124-27.

The article gave an overview of statistical data from 1970 to 1980 collected by the authors from different government agencies. The statistical results were presented in a number of formats including percentages, comparisons per 100,000 population, and graphs. Graphs included comparison of suicides by race, sex, age, state, and method.

The most striking conclusion formulated was that there existed a steady increase of suicide among the 15 to 24 year old age group. The suicide rate has tripled in the years from 1950 to 1980. In the 1970's, 49,496 young Americans died by their own hand. Suicide in that time period was the third leading cause of death for 15 to 24 year olds.

Rosenberg, Mark L., Mercy, James A., Smith, Jack C., "Violence as a Public Problem: A New CDC and a New Alliance with Educators," Educational Horizon, 62 (Summer 1984), 124-27.

The article involved research data that was acquired for the Center for Disease Control on the epidemic of violent crimes that has swept the country. The research pointed out that suicide was one of the most frequently committed violent crimes among Americans. The authors made the case that violence needed to be treated as an important public health and medical problem. The authors pointed out that educators could help identify high risk youths, since they are in direct contact with that age group. American educators must be made aware of ways to identify these high risk young people. The educator is in prime position to make a professional referral for these youths. Teachers can help design health education programs that deal with topics such as violence, death, and suicides. The authors contend that teacher inservice training must be made available for the distribution of data. A well prepared, knowledgeable teacher may be in the best position to save a young person's life. One startling conclusion offered by Rosenberg was that one suicide is often followed by another in the same student population.

Smith, Kim Ph.D., Crawford, Sylvia Drs., "Suicidal Behavior Among "Normal" High School Students," Fourth Annual Conference on Suicide of Adults and Youth, Sept. 14 1984.

The authors stated that the youth suicide rates are only the most visible tip of the iceberg-like problem of depression and self-destructiveness. Smith and Crawford related that most of the suicidal data available was only an estimate derived from special sub-populations of attempters, usually attempters who had been hospitalized.

The Smith/Crawford study was founded on a random sampling of high school students. The cross-selection used made their study more a reflection of the normal adolescent population.

The testers cited some alarming statistical results, some of these results are listed:

1) 10.5 percent had made at least one suicide attempt.
2) 25.5 percent had made a plan or attempted suicide.
3) 62.6. percent had some degree of suicidal ideation.
4) Only 12.1 percent of the attempter received medical treatment.
5) There were nearly 100 attempters per actual suicide.

The Smith/Crawford study showed that not only does the deeply suicidal adolescent need attention but that most adolescents are troubled and in need of attention.

Weed, James A. Ph.D. "Suicide in the United States: 1958-1982," Mental Health, United States 1985, U.S. Department of Health and Human Services.

Weed's report was based on data obtained through the collaborated efforts of the state mental health authorities. The report was a collection of data for the years 1958-1982. Suicidal statistics and graphs representing suicidal topic areas such as total deaths, differentials by race and sex, age patterns and means of injury were given.

A summary was included by Weed to point out the suicidal trends that had emerged over the 25-year period. The most noticeable change was the rapid increase in suicide rates by teenagers and young adults.

Wright, Loyd S., "Suicidal Thoughts and Their Relationship to Family Stress and Personal Problems Among High School Seniors and College Undergraduates," Adolescence, Vol. XX No. 79 (Fall 1985), 575-80.

Wright's study of high school seniors and college students was an investigation of serious suicidal thoughts and the relationship with family stress, drinking and drug abuse, and delinquency in the group. Questionnaires were used to survey over 1100 students on topics related to delinquent behavior, drinking and drug abuse, family stress, and childhood happiness. The students with serious suicidal thoughts were placed in a group. The others were placed in a control group. A statistical analysis was made of the answers from both groups. Wright concluded, to a significant degree, that students with serious suicidal tendencies were likely to state that they had a poor relationship with their father, had parents with many conflicts or one parent who was often angry or depressed, received insufficient parental support, or had a father with a drinking problem.

Young, Thomas J., "Adolescent Suicide: The Clinical Manifestation of Alienation," The High School Journal, Oct./Nov. 1985, 55-59.

Young made a case for a link between adolescent suicide and four causal factors of alienation. Alienation causes ontological insecurity, a feeling of nothing. The three modes of insecurity common among suicidal adolescents are engulfment, implosion and petrification.

Young's research showed that all members of a social structure must have an identity, feel related and must be actively stimulated within the society. Suicidal adolescents often felt alone in a crowd or bored with life. Young concludes that educators, because schools form the adolescents social structure, must play a significant role in suicide prevention.

## WARNING SIGNS AND SUICIDAL CLUES

Deykin, Eva, "Assessing Suicidal Intent and Lethality, " Educational Horizon, 62 (Summer 1984), 134-37.

The article was broken into four categories: causes of a suicidal crisis, suicidal symptoms, suicidal intent, and educators' responses. Deykin stated only briefly some of the causes of deep suicidal distress. She went into depth on suicidal symptoms that could be easily noticed by an educator. A list of eleven symptoms was stated including a loss of interest in formerly pleasurable activities, withdrawal from usual peer groups, extreme boredom, and essays or poems that openly or implicitly consider suicide. Deykin discussed many intervention and prevention plans that educators can take when they recognize suicidal symptoms. Deykin states that "Assessing suicidal risk is not complicated nor does it require specialized training; it does, however, require a willingness to ask frank questions and to hear disquieting answers." Deykin pointed out ways of investigating whether the suicidal intent is strong and, if strong, is there lethal means available. Deykin's definition of suicidal intent is that degree to which a student wishes to end his or her life. Lethality of means reflects the plan or instruments the adolescent has to commit suicide. Follow up procedures by the educator can ensure the safety of the high risk adolescent. Teachers should maintain active contact with the student until a therapeutic relationship is well-established. Deykin's article was especially helpful as an educator's quick guide of student mental health problems.

Martin Nancy k., and Dixon, Paul N., "Adolescent Suicide: Myths, Recognition, and Evaluation," The School Counselor, March 1986, 265-71.

The authors gave a generalized statistical overview of adolescent suicide. Suicidal ideation was categorized by passive suicide, suicidal gestures, and impulsive suicide. The authors discussed symptoms of suicidal behavior, a few of which were depression, ambivalence, stress, and social isolation. Crisis intervention techniques were discussed by the author. An evaluation plan was listed for use when interviewing suicidal adolescents. The evaluation plan described the role of the counselor and the teacher in the crisis situation.

Mc Brien, Robert J., "Are You Thinking of Killing Yourself?: Confronting Students' Suicidal Thoughts," The School Counselor, Sept. 1983, 75-82.

Mc Brien formulated several studies into some helpful counseling strategies. Adolescent suicide is a developmental problem with identifiable danger signs, verbal statements and situational clues. Mc Brien outlined an assessment interview to determine the seriousness of the student's intent to commit suicide. Mc Brien used a ten question interview to serve as a data base for the measurement of suicidal intent. Arguments for use of a life contract were made by Mc Brien.

McIntosh, J. L. Ph.D., "Youth Suicide,"Address presented at LaSalle High School, South Bend, March 1987.

McIntosh presented facts and statistics covering the topic of suicide. In his presentation the topic was narrowed to adolescent suicide. Materials were distributed covering such suicidal categories as high risk groups, verbal and behavioral clues, symptoms and warning signs of depression, motives, and intervention techniques. A two hour presentation on the various aspects of youth suicide was delivered by McIntosh.

"Youth Suicide: A school approach for the prevention of youth suicide in Indiana," Report by The Indiana State Board of Health, Section I.

Section one of the booklet centered on identifying the at risk youth. The authors have identified several distress signals that indicate suicidal intent. Adolescents who are at risk were broken into two symptom related categories: depression and substance abusers.

The authors described what teen depression is and what its symptoms might be. The depressed youth often abuses drugs or alcohol but this was identified as a symptom of and not a cause of the depression. The author notes several depression related characteristics, and risk factors.

Substance abuse by youths could be a symptom of depresion or it could be an indicator of an adolescent that is at risk. Substance abuse carries its own set of symptoms and warning signs. Teacher must learn to recognize and deal with substance abuse.

## PREVENTION AND INTERVENTION

Hals, Elaine, "Suicide Prevention," Health Education, Vol. 16 (Aug/Sept 1985), 45-47.

Hals contended that fellow students can become the first line of defense in the battle for the prevention of youth suicide. She stated that all students need to be impressed with an awareness to others' emotional well-being. Hals stated that adolescents that have suicidal ideation were not crazy but just in need of help.

Students need to be educated as to why people commit suicide. They must also learn to recognize suicidal warning signs and be taught how they can help. The author presented an outline that discussed each of the previously listed topics.

Mc Brien, Robert J., "Coaching Clients to Manage Depression," The Personnel and Guidance Journal, March 1981, 429-32.

Depression was sighted as the major cause of suicide as researched by Mc Brien. The author presented a system of behavioral techniques that could aid students in managing their own depression.

Mc Brien's self-management system was intended to help depressed people experience more pleasant events. The author suggested that the depressed person needs to closely monitor daily events and accentuate the positive events. Mc Brien's technique was suggested for people who are not in great suicidal danger, because it was a behavioral modification technique that took place over several weeks.

Renfro, Jean, "Mission Possible: Adolescents Do Not Have To Self-Destruct," Education Horizon, 62 (Summer 1984), 143-43.

Renfro stated that the increase in chemical dependency among adolescents may be linked to the rising suicide rate. One out of four students resides in a home in which at least one family member has a chemical dependency. Drug overdosing was the chosen method of over 80% of adolescents who attempted suicide. Nearly 45% of all teenagers who committed suicide had used drugs or alcohol immediately prior to their deaths. It is believed that "getting loaded" reduces the fear of death, therefore, making the suicide easier.

Most adolescents that attempted suicide held four self-destruct perceptions: a feeling of powerlessness, the inability to control one's own environment, a feeling of being unappreciated, and the inability to make a contribution to a group. The only stable force in many young people's lives is school; this puts teachers in a unique position to identify at-risk pupils. If teachers can be taught to recognize the symptoms of suicide, they will be able to help decrease the rising statistics.

Shamoo, Tonia K. and Patros, Philip G., "Suicide Intervention Strategies for the Adolescent," Techniques, Vol. 1 (April 1985), 297-303.

The authors dispelled four common suicidal myths that often interfered with effective intervention strategy. The main body of the text described eight intervention strategies that work on three levels: the affective, the cognitive, and the behavioral. The authors stressed that their strategies were used as temporary intervention and that long term treatment was most often beyond the scope of the school personnel.

Youth Suicide Prevention Act, Statutes at Large, H.R. Bill 4650, 1982.

The House of Representative Bill 4650 was short-titled "Youth Suicide Prevention Act". The bill instructed the Secretary of Education to assist local educational and private non-profit agencies in the establishment and operation of youth suicide prevention programs. The bill sets guide lines for the Secretary to follow in forming applications and for the distribution of funds. Citizens interested in applying for federal grants would need to do so in accordance with this bill.

## EDUCATORS ROLE

Davis, John M. "Suicidal Crises In Schools," School Psychology Review, Vol 14, No.3 (1985), 313-24.

Davis discussed three aspects of youth suicide: the incidence, underlying theory, and intervention strategies. The section about the incidence of suicide was not as encompassing as were the other two sections.

The author described seven categories in which the suicidal youth can be classified. Davis augmented these theories by citing several researchers. A discussion of the child's evolution on the meaning of death was included.

The author's discussion of suicidal intervention included a list of five danger signs and how to be alert to these signs. Sample questions were provided for use in classifying the adolescent's suicidal potential. Davis addressed known facts about adolescent suicide and described ways in which school personnel can intervene to save young lives.

Ross, Charlotte P., "Teaching Children the Facts of Life and Death: Suicide Prevention in the Schools," Youth Suicide, 1985 Springer Publishing Company Inc., New York, 147-69.

In this chapter Ross described all aspects of suicide education in the schools. Topics span from research into why suicide needs to be taught, to the implementation of such a program in the San Mateo County Schools.

The author strongly urged the training of gatekeepers of the young, usually teachers, to be more observant of at risk identifiers. Ross also argued that all students need to be aware of classmates' warning signs and what to do when they receive such signals.

Ross concludes that a suicide prevention program can be incorporated into the public school. Only through increased knowledge can suicide intervention programs be successful.

Wellman, Mary, "The School Counselor's Role in the Communication of Suicidal Ideation by Adolescents," The School Counselor, Nov. 1984, 104-109.

Wellman adopted a five-stage model of suicidal behavior. The author derived the model from work done by J. Jacobs (1980) and personally acquired data. Wellman explained each of the five behavior stages and presented three case studies as examples. Progression through the five stages exhibited a steady downward spiral whereby problems and stress factors escalate.

Communication of suicidal intent occurred after stage five. Communications might appear in two form: verbalization or experimentation. Verbalization may include remarks by the adolescent that include how burdensome life is, or express a lack of self worth or possibly a distribution of personal belongings. Experimentation includes overdosing or wrist slashing. Although these actions are usually non-lethal, they do exhibit a desperate cry for help.

The author gives ten verbal or behavioral messages often communicated by suicidal adolescents. Wellman ends with recommended intervention strategies for educators.

"Youth Suicide: A school approach for the prevention of youth suicide in Indiana," Report by The Indiana State Board of Health, Section II.

Section two of the booklet dealt with treating the suicidal adolescent. The focus was on preventive measures that school personel, students, and parents can take to reduce a suicidal crisis. Technique outlines were given for intervention, assessment, and post suicidal treatments. Directories of national and local support groups and hotlines were sighted. An extensive bibliography and a information source list were included.

## SUMMARY

Traditionally, it is very difficult for adults to conceive that an adolescent may be suicidal. Adults view adolescence as a time full of life and energy. Our adult memories of adolecence are full of wonderful images. It is a time of life that adults often yearn to return. A teacher must remove these prejudicial memories of adolescence before he/she can be helpful in suicide prevention. An investigation must be made to see what can go wrong to sour this time period and eventually lead to suicide.

After examining suicide theories by Young, Davis, Smith and Crawford, and other literature on the subject, an underlying theme of alienation seems to emerge. Alienation can be experienced as a sense of powerlessness, meaninglessness, isolation, depression, hopelessness, helplessness, and haplessness. The causes of alienation are rooted in the ambivalence of adolescents and the transformation taking place in our society.

Alienation may be the most notable feature of our modern society. The divorce rate is above 50%, and 40% of households are headed by women. (Youth Suicide 1985:6) The breakdown of the nuclear family is very apparent. Families are moving more frequently, thus children must change

schools before long-term friendships can be developed. Lines of communication are not only broken but often never developed. These factors make the population, as a whole, more alienated.

Adolescents may be the most alienated subpopulation in this country. The societal structures break down and there is no clear-cut path from childhood to adulthood. Young people develop cognitive thinking and start to question fundamental beliefs. Tremendous physical and emotional changes are taking place. The security of dependency is being challenged by the excitement of independence. This can be a time of increased insecurity, vulnerability and value confusion. Along with independence comes a need for intimacy. Sexual beliefs and morals are being challenged by physical and hormonal changes. Interpersonal relationships are developed which bring in a new source of stress. These relationships help to cloud personal values and goals. Adolescents often develop identity confusion. The question, "Who am I?", may become "What do others want me to be?". The young adult is now at a point in time in which the self is not very important, alienation is very strong, and depression may follow.

The adolescent may now fit into one of Davis's suicidal types:

1) Psychosis or personality disintegration
2) Self-homicide
3) Retaliation for real or imaginary abandonment
4) Blackmail and/or manipulation
5) Rejoining a powerful lost-love
6) Atonement for unpardonable sins
7) A cry for help

The three most common adolescent suicide types are retaliation, blackmail, and a cry for help. One can, after a closer look, more easily see how a young adult can slip into one of these suicidal categories.

Retaliation for real or imaginary abandonment is characterized by a person that is using the suicide as a demonstration of power to compensate for feelings of helplessness and lack of control. Blackmail and manipulation is presented as the ultimate threat, "If you don't treat me better, you will be sorry." A cry for help is probably the most common suicidal type. A person with this type of suicidal manifestation feels overwhelmed and helpless. This type of person knows no other way to cope, so he/she turns to suicidal behavior.

## SUMMARY OF SUICIDAL WARNING SIGNS

Identification can be very difficult. Suicidal ideation is a subtle, steady, downward spiral whereby stress factors and problems escalate. This subtle decline is often clouded by a lack of, or minimal, communication skills. Suicidal behavior often follows a five stage model.(Wellman 1984:104) The child enters adolescence with longstanding childhood problems. A perception of unloving and rejecting parents causes a feeling of powerlessness and loneliness. New adolescent problems are added to, and complicate, the earlier difficulties. The adolescent becomes progressively less able to cope. Life stressors continue to mount. The young person will start to exhibit social isolation. A 'last straw' event takes place that severs the last remaining social relationship. The suicidal youth can see no hope or way out. The adolescent will self-justify his suicide immediately before the attempt.

An adolescent descending through the five stages will exhibit some suicidal symptoms. The most likely symptoms are depression, ambivalence, stress, and social isolation. These symptoms are interrelated and usually will not be found by themselves.

Depression is the major underlying factor in teen suicide. One study reported that 95% of the participants at a suicide prevention center suffered from some sort of depression. (Martin 1986:266) Depression can be an illness that acts as an accelerant of suicidal ideation; however, a note must be made that not all depressed youth are suicidal. A teenager diagnosed as depressed must be dealt with as if they are at suicide risk.

There are many symptoms of teenage depression. The following is a list of warning signs that may indicate a child's depression is suicidal:

Sadness (in children under six years of age, may be inferred from a persistently sad facial expression)
Anger and rage--typically expressed by verbal sarcasm and attack (angry outbursts)
Inability to concentrate or make decisions
Sensitivity with inclination to overreact to criticism
Fluctuations between indifference and apathy on one hand and talkativeness on the other
Feelings of defeat/failure
Poor self-esteem (self-criticism and blame, sense of personal failure)
Feelings of helplessness and decreased peer support
Withdrawing from friends, excessive television watching
Intense ambivalence between dependence and independence
Restlessness and agitation (inability to relax)
Mood swings--the quiet youngster becoming hyperactive, the outgoing youngster becoming withdrawn
Pessimism about the future
Changes in sleeping habits
Changes in eating habits

Adolescents may also exhibit masked depression symptoms. These symptoms may be characterized in the following ways:

- Risk-taking behavior (driving fast, recklessly)
- Chronic fatigue and boredom
- Accident proneness
- Repeated temper tantrums
- Aggressive behavior
- Rebellious refusal to work in class or cooperate in general
- Weight gain or loss (anorexia)
- Somatic problems (e.g., headache, stomach ache)

There is reason for concern when a young person shows signs of depression. There are four categories of clues (situational, behavior, emotional, and verbal) that indicate suicidal ideation. Examples of each type are listed:

Situational Clues:
- Recent loss of loved one - death, separation, divorce
- Anniversary of death or loss - especially suicide
- Alcohol or drug involvement
- Past suicide attempt

Behavior Clues:
- Talking and writing about suicide
- Giving away personal possessions
- Change in behaviors - eating and sleeping habits, sexual drives
- Ending relationships
- Crying frequently
- Buying weapons, pills, etc.

Emotional Clues:
- Sense of failure
- General lack of interest
- Feelings of helplessness
- Withdrawal/Isolation
- Feels like a burden to others

Verbal Clues:
- "I can't go on."
- "I have nothing to live for."
- "No one cares."
- "They won't have me to kick around anymore."
- "They're better off without me."

Students with any of the suicidal tendencies may compound the problem with drug and/or alcohol abuse. A high percentage of suicides take place within twenty-four hours of taking drugs and/or alcohol. Substance abuse impairs judgment, removes inhibitions, and heightens the sense of alienation.

An adolescent suicide attempt is very seldom a complete surprise. Eighty percent of the adolescents contemplating suicide will communicate suicidal ideation before they make the attempt. (Martin 1986:266) The educator must be aware of the warning signs and be ready to take action!

## RECOMMENDATION

Many factors are present when an adolescent takes his/her own life. These factors are most often not school related. The schools may not be a cause of the problem, but they do need to be a part of the solution. Most educators would prefer to be a part of the solution, but ignorance of what to do and a fear of doing the wrong thing renders many educators unwilling or unable to intervene effectively. Teachers must realize that this fear is unwarranted and to trust their own judgment. One must act if there is reason to believe someone is in danger of committing suicide. If the person is truly suicidal, attempted intervention cannot make things any worse.

The first step toward intervention is the recognition that the student has exhibited suicidal clues. Once you suspect that someone has suicidal ideation, you must ask them direct questions. It would not be out of place to pose this question, "It sounds as if you are having a rough time of it. Do you ever think about killing yourself?" Asking a person if they are going to commit suicide will not cause them to do so; it can only confirm your suspicions.

Most suicidal adolescents want to communicate their feelings. Eighty percent of those adolescents will tell someone about their manifestations before they make the attempt. (Martin 1986:266) The willingness to want to

communicate allows a caretaker to be of considerable assistance during a suicidal crisis. The conversation must, to be more effective, follow certain guidelines. These guidelines will form our intervention strategies. The discussion with the distraught youth will cover these points of emphasis: lethality assessment, clarification of the immediate crisis, authoritative role, projection of concerned feelings, resources, and contracts. (Shamoo 1985:299)

The lethality assessment must take place immediately upon confirmation of suicidal ideation. Ask if they have a suicidal plan. Has the person a means by which to do it? The more detailed the plan and the more available the weapon, the higher the risk. Questions about why are you doing it should not be used because it will be interpreted as accusatory and put the adolescent on the defense. Questions about when and where show concern and will open lines of communication. The person must not be left alone, if the assessment shows any degree of lethality, and the means of self-destruction must be removed.

If possible, the precipitated event of the current crisis should be identified. When the event is identified, it may be possible to reduce or eliminate the anxiety the person is manifesting. A suicidal person is often vague

about the cause, so you must try to get him/her to focus on the true cause. If someone were to say, "Everyone hates me," a good response would be, "Tell me someone that hates you." When the precipitating event is identified, a summarizing of the event with the adolescent shows concern and helps him/her to focus on the problem. Focusing is important to relieve the feeling of being overwhelmed.

Suicidal adolescents often exhibit ambivalence, lack of coping strategies, and poor decision making abilities. Taking a strong authoritative role allows you to set goals and boundaries covering the crisis. Listen with compassion and exhibit maturity in your reactions. An authority figure can act as a substitute for weak and immature coping and decision making abilities.

A suicidal adolescent must feel free to discuss concerns and fears. Active listening is paramount in establishing such a relationship. While listening, care must be taken to avoid making judgments either in favor of or opposed to the problem. There is no need to try to know all the answers, just be interested.

The more the adolescent talks the stronger the relationship will become and trust will soon develop. Respond to the conversation by paraphrasing what was shared. Use their name as often as possible when responding so as to

convey an affiliation between the two of you. Help relieve their guilt by expressing to them that talking about their feelings is the right thing to do. The goal of the conversation is to allow an outward expression of feelings to help alleviate the suicidal cry for help.

Make the adolescent agree to make contact before they take any suicidal action. Let the student know of the availability of other help groups and hot lines.

From the onset adolescents must know that you will share their suicidal ideation with others. They must know that you will tell their parents, teachers, and friends. Confidentiality is to be avoided. As a teacher, you are not liable for breach of confidence, and this issue must be secondary. It is important to develop a support network of meaningful relations to help the adolescent cope. The adolescent will be ambivalent about sharing his/her thoughts and must be reassured that it is best to let others know.

The caretaker must be familiar with local resources, such as mental health centers, crisis intervention groups, hot lines, bereavement support groups, and welfare agencies. In St. Joseph County these include Madison Center, Family & Children's Center, Hotline, Compassionate Friends, and the County Welfare.

The possibility of suicide exists no matter what precautions are taken. Suicide is an individual choice and the wrong decision may be made. Survivors of a suicide often feel guilt and shame because of the self-destruction of someone close. Care must be taken with these survivors to avoid copycat suicides. Again the key to prevention is communication. Sharing the guilt feelings and fear brought on by the suicide is the only way to alleviate their anxiety.

## CONCLUSION

The average classroom of thirty students contains sixteen students whose parents are divorced and twenty-one students who drink. Our society is on the move. Adolescents have a difficult time establishing relationships. They grow up spending hours with a television set. The T.V. becomes more than entertainment; it is baby sitter, companion, and teacher. Normal family-evolved morals are a thing of the past; instead, the teenager learns from the screen a warped fantasy created life style. The adolescent is thrust into the adult world before his/her emotional maturity can be developed. The path to adulthood is not clearly marked. Poorly developed communication skills make the journey even more perilous. The best of our young people can make the wrong, fatal decision.

The classroom environment may be the only real part of the adolescent's life. Classroom teachers may not want the responsibility for life and death, but the charge may be cast upon them. Ignoring suicidal tendencies by a student may be easy enough to do, but the fatal consequences may be more difficult to forget. Teachers must be willing to help an adolescent during a crisis. No excuse can be made to withdraw from this most important of teaching responsibilities!

## NOTES

I must make an end note of a personal nature. Early in the 1987 school year a senior at LaSalle High School committed suicide. Had this young lady lived, she would have been the 1988 class valedictorian. This study has been a great deal of help to me in dealing with this tragedy. I was better prepared to help students and faculty who were deeply affected by this tremendous loss. As educators, we must be prepared for this, the most tragic of circumstances!

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